

1 AN ACT concerning insurance.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 5. The Illinois Insurance Code is amended by  
5 renumbering Section 356z.14 as added by Public Act 95-1005, by  
6 changing and renumbering Section 356z.15 as added by Public Act  
7 96-639, and by adding Section 356z.18 as follows:

8 (215 ILCS 5/356z.15)

9 Sec. 356z.15 ~~356z.14~~. Habilitative services for children.

10 (a) As used in this Section, "habilitative services" means  
11 occupational therapy, physical therapy, speech therapy, and  
12 other services prescribed by the insured's treating physician  
13 pursuant to a treatment plan to enhance the ability of a child  
14 to function with a congenital, genetic, or early acquired  
15 disorder. A congenital or genetic disorder includes, but is not  
16 limited to, hereditary disorders. An early acquired disorder  
17 refers to a disorder resulting from illness, trauma, injury, or  
18 some other event or condition suffered by a child prior to that  
19 child developing functional life skills such as, but not  
20 limited to, walking, talking, or self-help skills. Congenital,  
21 genetic, and early acquired disorders may include, but are not  
22 limited to, autism or an autism spectrum disorder, cerebral  
23 palsy, and other disorders resulting from early childhood

1 illness, trauma, or injury.

2 (b) A group or individual policy of accident and health  
3 insurance or managed care plan amended, delivered, issued, or  
4 renewed after the effective date of this amendatory Act of the  
5 95th General Assembly must provide coverage for habilitative  
6 services for children under 19 years of age with a congenital,  
7 genetic, or early acquired disorder so long as all of the  
8 following conditions are met:

9 (1) A physician licensed to practice medicine in all  
10 its branches has diagnosed the child's congenital,  
11 genetic, or early acquired disorder.

12 (2) The treatment is administered by a licensed  
13 speech-language pathologist, licensed audiologist,  
14 licensed occupational therapist, licensed physical  
15 therapist, licensed physician, licensed nurse, licensed  
16 optometrist, licensed nutritionist, licensed social  
17 worker, or licensed psychologist upon the referral of a  
18 physician licensed to practice medicine in all its  
19 branches.

20 (3) The initial or continued treatment must be  
21 medically necessary and therapeutic and not experimental  
22 or investigational.

23 (c) The coverage required by this Section shall be subject  
24 to other general exclusions and limitations of the policy,  
25 including coordination of benefits, participating provider  
26 requirements, restrictions on services provided by family or

1 household members, utilization review of health care services,  
2 including review of medical necessity, case management,  
3 experimental, and investigational treatments, and other  
4 managed care provisions.

5 (d) Coverage under this Section does not apply to those  
6 services that are solely educational in nature or otherwise  
7 paid under State or federal law for purely educational  
8 services. Nothing in this subsection (d) relieves an insurer or  
9 similar third party from an otherwise valid obligation to  
10 provide or to pay for services provided to a child with a  
11 disability.

12 (e) Coverage under this Section for children under age 19  
13 shall not apply to treatment of mental or emotional disorders  
14 or illnesses as covered under Section 370 of this Code as well  
15 as any other benefit based upon a specific diagnosis that may  
16 be otherwise required by law.

17 (f) The provisions of this Section do not apply to  
18 short-term travel, accident-only, limited, or specific disease  
19 policies.

20 (g) Any denial of care for habilitative services shall be  
21 subject to appeal and external independent review procedures as  
22 provided by Section 45 of the Managed Care Reform and Patient  
23 Rights Act.

24 (h) Upon request of the reimbursing insurer, the provider  
25 under whose supervision the habilitative services are being  
26 provided shall furnish medical records, clinical notes, or

1 other necessary data to allow the insurer to substantiate that  
2 initial or continued medical treatment is medically necessary  
3 and that the patient's condition is clinically improving. When  
4 the treating provider anticipates that continued treatment is  
5 or will be required to permit the patient to achieve  
6 demonstrable progress, the insurer may request that the  
7 provider furnish a treatment plan consisting of diagnosis,  
8 proposed treatment by type, frequency, anticipated duration of  
9 treatment, the anticipated goals of treatment, and how  
10 frequently the treatment plan will be updated.

11 (i) Rulemaking authority to implement this amendatory Act  
12 of the 95th General Assembly, if any, is conditioned on the  
13 rules being adopted in accordance with all provisions of the  
14 Illinois Administrative Procedure Act and all rules and  
15 procedures of the Joint Committee on Administrative Rules; any  
16 purported rule not so adopted, for whatever reason, is  
17 unauthorized.

18 (Source: P.A. 95-1049, eff. 1-1-10; revised 10-23-09.)

19 (215 ILCS 5/356z.17)

20 Sec. 356z.17 ~~356z.15~~. Wellness coverage.

21 (a) A group or individual policy of accident and health  
22 insurance or managed care plan amended, delivered, issued, or  
23 renewed after January 1, 2010 (the effective date of Public Act  
24 96-639) ~~this amendatory Act of the 96th General Assembly~~ that  
25 provides coverage for hospital or medical treatment on an

1 expense incurred basis may offer a reasonably designed program  
2 for wellness coverage that allows for a reward, a contribution,  
3 a reduction in premiums or reduced medical, prescription drug,  
4 or equipment copayments, coinsurance, or deductibles, or a  
5 combination of these incentives, for participation in any  
6 health behavior wellness, maintenance, or improvement program  
7 approved or offered by the insurer or managed care plan. The  
8 insured or enrollee may be required to provide evidence of  
9 participation in a program. Individuals unable to participate  
10 in these incentives due to an adverse health factor shall not  
11 be penalized based upon an adverse health status.

12 (b) For purposes of this Section, "wellness coverage" means  
13 health care coverage with the primary purpose to engage and  
14 motivate the insured or enrollee through: incentives;  
15 provision of health education, counseling, and self-management  
16 skills; identification of modifiable health risks; and other  
17 activities to influence health behavior changes.

18 For the purposes of this Section, "reasonably designed  
19 program" means a program of wellness coverage that has a  
20 reasonable chance of improving health or preventing disease; is  
21 not overly burdensome; does not discriminate based upon factors  
22 of health; and is not otherwise contrary to law.

23 (c) Incentives as outlined in this Section are specific and  
24 unique to the offering of wellness coverage and have no  
25 application to any other required or optional health care  
26 benefit.

1           (d) Such wellness coverage must satisfy the requirements  
2 for an exception from the general prohibition against  
3 discrimination based on a health factor under the federal  
4 Health Insurance Portability and Accountability Act of 1996  
5 (P.L. 104-191; 110 Stat. 1936), including any federal  
6 regulations that are adopted pursuant to that Act.

7           (e) A plan offering wellness coverage must do the  
8 following:

9           (i) give participants the opportunity to qualify for  
10 offered incentives at least once a year;

11           (ii) allow a reasonable alternative to any individual  
12 for whom it is unreasonably difficult, due to a medical  
13 condition, to satisfy otherwise applicable wellness  
14 program standards. Plans may seek physician verification  
15 that health factors make it unreasonably difficult or  
16 medically inadvisable for the participant to satisfy the  
17 standards; and

18           (iii) not provide a total incentive that exceeds 20% of  
19 the cost of employee-only coverage. The cost of  
20 employee-only coverage includes both employer and employee  
21 contributions. For plans offering family coverage, the 20%  
22 limitation applies to cost of family coverage and applies  
23 to the entire family.

24           (f) A reward, contribution, or reduction established under  
25 this Section and included in the policy or certificate does not  
26 violate Section 151 of this Code.

1 (Source: P.A. 96-639, eff. 1-1-10; revised 10-21-09.)

2 (215 ILCS 5/356z.18 new)

3 Sec. 356z.18. Prosthetic and customized orthotic devices.

4 (a) For the purposes of this Section:

5 "Customized orthotic device" means a supportive device for  
6 the body or a part of the body, the head, neck, or extremities,  
7 and includes the replacement or repair of the device based on  
8 the patient's physical condition as medically necessary,  
9 excluding foot orthotics defined as an in-shoe device designed  
10 to support the structural components of the foot during  
11 weight-bearing activities.

12 "Licensed provider" means a prosthetist, orthotist, or  
13 pedorthist licensed to practice in this State.

14 "Prosthetic device" means an artificial device to replace,  
15 in whole or in part, an arm or leg and includes accessories  
16 essential to the effective use of the device and the  
17 replacement or repair of the device based on the patient's  
18 physical condition as medically necessary.

19 (b) This amendatory Act of the 96th General Assembly shall  
20 provide benefits to any person covered thereunder for expenses  
21 incurred in obtaining a prosthetic or custom orthotic device  
22 from any Illinois licensed prosthetist, licensed orthotist, or  
23 licensed pedorthist as required under the Orthotics,  
24 Prosthetics, and Pedorthics Practice Act.

25 (c) A group or individual major medical policy of accident

1 or health insurance or managed care plan or medical, health, or  
2 hospital service corporation contract that provides coverage  
3 for prosthetic or custom orthotic care and is amended,  
4 delivered, issued, or renewed 6 months after the effective date  
5 of this amendatory Act of the 96th General Assembly must  
6 provide coverage for prosthetic and orthotic devices in  
7 accordance with this subsection (c). The coverage required  
8 under this Section shall be subject to the other general  
9 exclusions, limitations, and financial requirements of the  
10 policy, including coordination of benefits, participating  
11 provider requirements, utilization review of health care  
12 services, including review of medical necessity, case  
13 management, and experimental and investigational treatments,  
14 and other managed care provisions under terms and conditions  
15 that are no less favorable than the terms and conditions that  
16 apply to substantially all medical and surgical benefits  
17 provided under the plan or coverage.

18 (d) The policy or plan or contract may require prior  
19 authorization for the prosthetic or orthotic devices in the  
20 same manner that prior authorization is required for any other  
21 covered benefit.

22 (e) Repairs and replacements of prosthetic and orthotic  
23 devices are also covered, subject to the co-payments and  
24 deductibles, unless necessitated by misuse or loss.

25 (f) A policy or plan or contract may require that, if  
26 coverage is provided through a managed care plan, the benefits

1 mandated pursuant to this Section shall be covered benefits  
2 only if the prosthetic or orthotic devices are provided by a  
3 licensed provider employed by a provider service who contracts  
4 with or is designated by the carrier, to the extent that the  
5 carrier provides in-network and out-of-network service, the  
6 coverage for the prosthetic or orthotic device shall be offered  
7 no less extensively.

8 (g) The policy or plan or contract shall also meet adequacy  
9 requirements as established by the Health Care Reimbursement  
10 Reform Act of 1985 of the Illinois Insurance Code.

11 (h) This Section shall not apply to accident only,  
12 specified disease, short-term hospital or medical, hospital  
13 confinement indemnity, credit, dental, vision, Medicare  
14 supplement, long-term care, basic hospital and  
15 medical-surgical expense coverage, disability income insurance  
16 coverage, coverage issued as a supplement to liability  
17 insurance, workers' compensation insurance, or automobile  
18 medical payment insurance.

19 Section 10. The Health Maintenance Organization Act is  
20 amended by changing Section 5-3 as follows:

21 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

22 Sec. 5-3. Insurance Code provisions.

23 (a) Health Maintenance Organizations shall be subject to  
24 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,

1 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,  
2 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,  
3 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,  
4 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15 ~~356z.14,~~  
5 356z.17 ~~356z.15,~~ 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a,  
6 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408,  
7 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection  
8 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,  
9 XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

10 (b) For purposes of the Illinois Insurance Code, except for  
11 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health  
12 Maintenance Organizations in the following categories are  
13 deemed to be "domestic companies":

14 (1) a corporation authorized under the Dental Service  
15 Plan Act or the Voluntary Health Services Plans Act;

16 (2) a corporation organized under the laws of this  
17 State; or

18 (3) a corporation organized under the laws of another  
19 state, 30% or more of the enrollees of which are residents  
20 of this State, except a corporation subject to  
21 substantially the same requirements in its state of  
22 organization as is a "domestic company" under Article VIII  
23 1/2 of the Illinois Insurance Code.

24 (c) In considering the merger, consolidation, or other  
25 acquisition of control of a Health Maintenance Organization  
26 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

1           (1) the Director shall give primary consideration to  
2 the continuation of benefits to enrollees and the financial  
3 conditions of the acquired Health Maintenance Organization  
4 after the merger, consolidation, or other acquisition of  
5 control takes effect;

6           (2) (i) the criteria specified in subsection (1) (b) of  
7 Section 131.8 of the Illinois Insurance Code shall not  
8 apply and (ii) the Director, in making his determination  
9 with respect to the merger, consolidation, or other  
10 acquisition of control, need not take into account the  
11 effect on competition of the merger, consolidation, or  
12 other acquisition of control;

13           (3) the Director shall have the power to require the  
14 following information:

15           (A) certification by an independent actuary of the  
16 adequacy of the reserves of the Health Maintenance  
17 Organization sought to be acquired;

18           (B) pro forma financial statements reflecting the  
19 combined balance sheets of the acquiring company and  
20 the Health Maintenance Organization sought to be  
21 acquired as of the end of the preceding year and as of  
22 a date 90 days prior to the acquisition, as well as pro  
23 forma financial statements reflecting projected  
24 combined operation for a period of 2 years;

25           (C) a pro forma business plan detailing an  
26 acquiring party's plans with respect to the operation

1 of the Health Maintenance Organization sought to be  
2 acquired for a period of not less than 3 years; and

3 (D) such other information as the Director shall  
4 require.

5 (d) The provisions of Article VIII 1/2 of the Illinois  
6 Insurance Code and this Section 5-3 shall apply to the sale by  
7 any health maintenance organization of greater than 10% of its  
8 enrollee population (including without limitation the health  
9 maintenance organization's right, title, and interest in and to  
10 its health care certificates).

11 (e) In considering any management contract or service  
12 agreement subject to Section 141.1 of the Illinois Insurance  
13 Code, the Director (i) shall, in addition to the criteria  
14 specified in Section 141.2 of the Illinois Insurance Code, take  
15 into account the effect of the management contract or service  
16 agreement on the continuation of benefits to enrollees and the  
17 financial condition of the health maintenance organization to  
18 be managed or serviced, and (ii) need not take into account the  
19 effect of the management contract or service agreement on  
20 competition.

21 (f) Except for small employer groups as defined in the  
22 Small Employer Rating, Renewability and Portability Health  
23 Insurance Act and except for medicare supplement policies as  
24 defined in Section 363 of the Illinois Insurance Code, a Health  
25 Maintenance Organization may by contract agree with a group or  
26 other enrollment unit to effect refunds or charge additional

1 premiums under the following terms and conditions:

2 (i) the amount of, and other terms and conditions with  
3 respect to, the refund or additional premium are set forth  
4 in the group or enrollment unit contract agreed in advance  
5 of the period for which a refund is to be paid or  
6 additional premium is to be charged (which period shall not  
7 be less than one year); and

8 (ii) the amount of the refund or additional premium  
9 shall not exceed 20% of the Health Maintenance  
10 Organization's profitable or unprofitable experience with  
11 respect to the group or other enrollment unit for the  
12 period (and, for purposes of a refund or additional  
13 premium, the profitable or unprofitable experience shall  
14 be calculated taking into account a pro rata share of the  
15 Health Maintenance Organization's administrative and  
16 marketing expenses, but shall not include any refund to be  
17 made or additional premium to be paid pursuant to this  
18 subsection (f)). The Health Maintenance Organization and  
19 the group or enrollment unit may agree that the profitable  
20 or unprofitable experience may be calculated taking into  
21 account the refund period and the immediately preceding 2  
22 plan years.

23 The Health Maintenance Organization shall include a  
24 statement in the evidence of coverage issued to each enrollee  
25 describing the possibility of a refund or additional premium,  
26 and upon request of any group or enrollment unit, provide to

1 the group or enrollment unit a description of the method used  
2 to calculate (1) the Health Maintenance Organization's  
3 profitable experience with respect to the group or enrollment  
4 unit and the resulting refund to the group or enrollment unit  
5 or (2) the Health Maintenance Organization's unprofitable  
6 experience with respect to the group or enrollment unit and the  
7 resulting additional premium to be paid by the group or  
8 enrollment unit.

9 In no event shall the Illinois Health Maintenance  
10 Organization Guaranty Association be liable to pay any  
11 contractual obligation of an insolvent organization to pay any  
12 refund authorized under this Section.

13 (g) Rulemaking authority to implement Public Act 95-1045  
14 ~~this amendatory Act of the 95th General Assembly~~, if any, is  
15 conditioned on the rules being adopted in accordance with all  
16 provisions of the Illinois Administrative Procedure Act and all  
17 rules and procedures of the Joint Committee on Administrative  
18 Rules; any purported rule not so adopted, for whatever reason,  
19 is unauthorized.

20 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;  
21 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;  
22 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.  
23 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; revised  
24 10-23-09.)

25 Section 15. The Voluntary Health Services Plans Act is

1 amended by changing Section 10 as follows:

2 (215 ILCS 165/10) (from Ch. 32, par. 604)

3 Sec. 10. Application of Insurance Code provisions. Health  
4 services plan corporations and all persons interested therein  
5 or dealing therewith shall be subject to the provisions of  
6 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,  
7 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,  
8 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,  
9 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,  
10 356z.14, 356z.15 ~~356z.14~~, 356z.18, 364.01, 367.2, 368a, 401,  
11 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7)  
12 and (15) of Section 367 of the Illinois Insurance Code.

13 Rulemaking authority to implement Public Act 95-1045 ~~this~~  
14 ~~amendatory Act of the 95th General Assembly~~, if any, is  
15 conditioned on the rules being adopted in accordance with all  
16 provisions of the Illinois Administrative Procedure Act and all  
17 rules and procedures of the Joint Committee on Administrative  
18 Rules; any purported rule not so adopted, for whatever reason,  
19 is unauthorized.

20 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;  
21 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.  
22 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,  
23 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;  
24 96-328, eff. 8-11-09; revised 9-25-09.)

1           Section 95. No acceleration or delay. Where this Act makes  
2 changes in a statute that is represented in this Act by text  
3 that is not yet or no longer in effect (for example, a Section  
4 represented by multiple versions), the use of that text does  
5 not accelerate or delay the taking effect of (i) the changes  
6 made by this Act or (ii) provisions derived from any other  
7 Public Act.